A5

Health Services
LOS ANGELES COUNTY

EMPLOYEE HEALTH SERVICES

PROFESSIONAL STAFF ASSOCIATION HEALTH CLEARANCE INSTRUCTIONS

Welcome to Los Angeles County, Department of Health Services. You are required to be cleared by Employee Health Services (EHS) prior to beginning your assignment. You must successfully complete the Human Resources in-processing and criminal background check prior to beginning the EHS health clearance process. In this packet includes health screening forms and questionnaires that should be completed prior to your visit to EHS. The completed forms should be presented to EHS on the day of your appointment/visit. Please bring the following forms with you to EHS at your appointment/visit. **There are two options to meet this requirement:**

OPTION 1: Health screening provided by your physician or licensed health care professional

Return completed **Form E2** to EHS:

- ☑ Section I - Completed by a licensed health care professional
- ☑ Section II - Completed by you
- ☑ Section III - Completed by your employer, school, or self (personal contract)

OPTION 2: Health screening provided by EHS

Please bring the following forms with you to EHS:

- ☐ **B-NC** Page 1 completed by you
- ☐ **K-NC** Complete as applicable
- ☐ **T1-NC** Must be signed in the presence of EHS
- ☐ **T4-NC** Must be signed in the presence of EHS

Only if respiratory protection is needed for your assignment, you must complete ***one*** of the following medical questionnaire below:

- ☐ **O-NC** For respirator greater than N-95 mask ***OR***
- ☐ **P-NC** For N-95 respirator

By providing these documents, you can help expedite the processing for an EHS health clearance:

1. **Tuberculosis (TB) Test Record** *(a copy of any **one** of the following)*:

Completed within the last 12 months

- ☐ 2 negative Tuberculin Skin Test (TST) records documented in millimeters (This is a two-step TST)
- ☐ 1 negative TST record documented in millimeters
- ☐ 1 negative single blood assay for M. tuberculosis (BAMT)

For a positive TB result, submit a Chest X-Ray Report within the last 12 months

- ☐ 1 positive TST record documented in millimeters with a Chest X-Ray Report
- ☐ 1 positive BAMT record with a Chest X-Ray Report

2. **Immunizations Record** and/or Titers to the following:

☐ Measles	☐ Varicella	☐ Acellular Pertussis
☐ Mumps	☐ Tetanus	☐ Influenza
☐ Rubella	☐ Diptheria	☐ Hepatitis B

The following will be obtained at EHS:

- o A two-step TST will be conducted if you cannot provide documentation of 2 negative TST records within the previous 12 months. This may require a total of 3 office visits.
- o A TST will be conducted if you can only provide documentation of 1 negative TST record within the previous 12 months. This may require a total of 2 office visits.
- o If you have been documented with a positive TST or positive BAMT result, you will be required to have a baseline chest x-ray prior to work assignment **OR** provide written documentation of a normal chest x-ray taken no more than 12 months prior to work assignment.
- o EHS will assess the immunization documents you provide to determine if you meet evidence of immunity to vaccine-preventable diseases as a requirement for your work assignment.

APPOINTMENT

☐ **YOUR APPOINTMENT IS SCHEDULED ON _____ AT _____ AM / PM.**

☐ **APPOINTMENT NEEDED, PLEASE CALL _____.**

☐ **NO APPOINTMENT NEEDED, PLEASE WALK IN DURING THE FOLLOWING OFFICE HOURS:**

DAY	TIME	LOCATION
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		

If you have any questions or need assistance, please contact the facility EHS office.

Thank you,

DHS EMPLOYEE HEALTH SERVICE

All workforce member EHS health records are confidential in accordance with federal, state and regulatory requirements.

E2

Health Services
LOS ANGELES COUNTY

EMPLOYEE HEALTH SERVICES

NON-DHS/NON-COUNTY WORKFORCE MEMBER HEALTH CLEARANCE CERTIFICATION

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	IDENTIFICATION NO.:

JOB CLASSIFICATION:	WORK FACILITY:	DEPT/DIVISION:	WORK AREA/UNIT:	SHIFT:

NAME OF SCHOOL/EMPLOYER *(If applicable)*:	PHONE NO.:	CONTACT PERSON:

Completion of this certificate certifies the individual identified above has met the Los Angeles County Department of Health Services (DHS) Pre-placement OR Annual health clearance requirements in accordance with DHS policy.

I. FOR COMPLETION BY THE PHYSICIAN OR LICENSED HEALTH CARE PROFESSIONAL (PLHCP)

INSTRUCTIONS TO THE PLHCP: Please complete the following forms AND verify the forms are completed fully. All fields on the forms must be completed in order to meet DHS health clearance requirements to work in DHS health care facilities. Return completed forms to the individual named above.

A. FOR PRE-PLACEMENT HEALTH SCREENING *(ONE TIME use for initial pre-placement only):*

- ☐ **B-NC** Tuberculosis History and Evidence of Immunity
  - ☐ Workforce member declined vaccination(s): _____
  - **NOTE:** If workforce member (WFM) declined vaccination(s), must attach medical documentation and clearance to work in a health care environment and submit to DHS-EHS.
  - *Declination for Measles, Mumps, Rubella, & Varicella must specify reason for declination on Form K-NC.*
- ☐ **K-NC** Declination Form, as applicable *(Submit to DHS-EHS)*
- ☐ **N-NC** FIT Test *(Only if respirator is needed for job assignment. Must complete **ONE** of the following medical questionnaire below prior to Fit Test, then every 4 years thereafter or as needed)*
  - ☐ **O-NC** Respirator Medical Questionnaire *(for respirators greater than N-95 respirator)* ***OR***
  - ☐ **P-NC** Appendix B – ATD Respirator Medical Evaluation Questionnaire *(for N-95 respirator)*

B. FOR ANNUAL HEALTH SCREENING *(Use annually):*

- ☐ **E-NC** Annual Health Screening
  - **NOTE:** For new TB Conversion, must attach Form E-NC and submit to DHS-EHS.
- ☐ **K-NC** Declination Form, as applicable *(Submit to DHS-EHS)*
- ☐ **N-NC** FIT Test *(Only if respirator is needed for job assignment. If this is first time Fit Test, WFM must complete **ONE** of the following medical questionnaire below prior to Fit Test, then every 4 years thereafter or as needed)*
  - ☐ **O-NC** Respirator Medical Questionnaire *(for respirators greater than N-95 respirator)* ***OR***
  - ☐ **P-NC** Appendix B – ATD Respirator Medical Evaluation Questionnaire *(for N-95 respirator)*

DATE OF HEALTH CLEARANCE:_____

I certify that the individual identified above has met the Los Angeles County Department of Health Services Pre-placement OR Annual health screening requirements AND verified completion of the forms.

PHYSICIAN OR LICENSED HEALTH CARE PROFESSIONAL SIGNATURE:	DATE:

PRINT NAME:	LICENSE NO.:

FACILITY NAME/ADDRESS:	PHONE NO.:

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	IDENTIFICATION NO.:

II. FOR COMPLETION BY THE WORKFORCE MEMBER

INSTRUCTION TO THE WORKFORCE MEMBER: You must provide authorization to release your health information to your School/Employer and to DHS-EHS by signing below. Return all completed forms to your School/Employer for verification of completion and to store source documents.

I authorize the release of my health information as listed in Section I to my School/Employer and to DHS-EHS, and upon request by DHS-EHS for regulatory requirements and auditing purposes. The purpose of releasing my health information is to meet DHS pre-placement or annual health screening requirements. DHS forms shall be maintained and filed at my School/Employer and at DHS-EHS as applicable. I understand that my School/Employer and DHS-EHS may not use or disclose my health information unless another authorization is obtained from me or unless such use or disclosure is specially required or permitted by law. By signing this, I am authorizing the release of my health information.

PRINT NAME:	SIGNATURE:	DATE:

III. FOR COMPLETION BY THE SCHOOL/EMPLOYER

INSTRUCTION TO THE SCHOOL/EMPLOYER: You must verify all forms are accurately completed and ensure workforce member (WFM) has met the DHS health clearance requirements. Sign below and return this certificate (original, not a copy) including applicable form(s) as specified in Section I to DHS-EHS. Certificate must be presented to DHS-EHS for final health clearance.

In accordance with DHS policy, the WFM's School/Employer shall:

1. Maintain and file WFM's health information at the WFM's School/Employer, and must ensure the confidentiality and privacy of WFM's health information.
2. Ensure the above WFM completes a health screening annually **by the end of the month of last health screening.** Failure to provide documentation of timely health screening/clearance will result in immediate termination of assignment and placement in a "Do Not Send" status until compliant.
3. Provide health surveillance/post-exposure services to WFM. If the WFM's School/Employer chooses to have DHS-EHS perform such surveillance/post-exposure services, the WFM's School/Employer will be billed, as appropriate.

As the WFM's School/Employer, I certify that I have verified DHS forms are complete to ensure the health clearance requirements are complete and, upon DHS request, will supply supporting document(s) within four (4) hours. WFM will comply with DHS policy and will complete health screening annually.

PRINT NAME:	SIGNATURE:		DATE:
E-MAIL ADDRESS:	NAME OF SCHOOL/EMPLOYER:		PHONE NO.:
ADDRESS:		STATE:	ZIP CODE:

MAKE A COPY FOR YOUR RECORDS
SUBMIT THIS ORIGINAL FORM INCLUDING ANY DECLINATION (K-NC)

DHS-EHS STAFF ONLY		
DATE CLEARED BY EHS:	PRINT NAME:	SIGNATURE:

DHS-EHS is to provide Form A2 or E3 to WFM for Area/Unit File

B-NC

Health Services
LOS ANGELES COUNTY

EMPLOYEE HEALTH SERVICES

CONFIDENTIAL

NON-DHS/NON-COUNTY WORKFORCE MEMBER TUBERCULOSIS HISTORY AND EVIDENCE OF IMMUNITY

See General Instructions on Last Page

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	IDENTIFICATION NO.:

HOME ADDRESS:	CITY	STATE:	ZIP CODE:

E-MAIL ADDRESS:	HOME PHONE NO.:	CELL PHONE NO.:

JOB CLASSIFICATION:	DHS FACILITY:	DEPT/DIVISION:	WORK AREA/UNIT:	SHIFT:

NAME OF SCHOOL/EMPLOYER *(If applicable)*:	PHONE NO.:	CONTACT PERSON:

FOR COMPLETION BY WORKFORCE MEMBER (WFM)

TUBERCULOSIS QUESTIONNAIRE

YES	NOT SURE	NO	
			TUBERCULOSIS (TB) HISTORY
☐	☐	☐	1. Do you have history of a negative TB skin test?
☐	☐	☐	2. Do you have documentation of your negative test from the last 12 months?
☐	☐	☐	3. Do you have a history of a positive TB skin test?
☐	☐	☐	4. Do you have documentation of your positive skin test in millimeters?
☐	☐	☐	5. Do you have documentation of a chest X-ray within the last year?
☐	☐	☐	6. Have you received treatment for TB (INH)?
☐	☐	☐	If "yes", how many months? _____
☐	☐	☐	7. Do you have treatment documentation?
☐	☐	☐	8. Have you ever been diagnosed as having active or infectious TB?
☐	☐	☐	9. Have you received a TB vaccine called BCG?
☐	☐	☐	10. Have you had a weakened immune system due to (check all that applies):
			☐ Chemotherapy ☐ HIV ☐ Organ transplant ☐ Leukemia ☐ Cancer or medications ☐ Hodgkin's Disease ☐ Steroids (e.g., prednisone)
			Note: Having immunodeficiency increases a person's risk for active TB infection/disease. If you think you may be immunocompromised you should consult with your physician or licensed health care professional. DHS-EHS does not test for HIV or related diseases.
			TUBERCULOSIS (TB) SCREENING
☐	☐	☐	11. Do you have a cough lasting longer than three (3) weeks?
☐	☐	☐	12. Do you cough up blood?
☐	☐	☐	13. Do you have unexplained or unintended weight loss?
☐	☐	☐	14. Do you have night sweats (not related to menopause)?
☐	☐	☐	15. Do you have a fever or chills?
☐	☐	☐	16. Do you have excessive sputum?
☐	☐	☐	17. Do you have excessive fatigue?
☐	☐	☐	18. Have you had recent close contact with a person with TB?

NON-DHS/NON-COUNTY WORKFORCE MEMBER SIGNATURE	DATE

LAST NAME	FIRST NAME	BIRTHDATE	IDENTIFICATION NO.

FOR COMPLETION BY EMPLOYEE HEALTH STAFF – OR – DESIGNATED WFM AGENCY

TUBERCULOSIS DOCUMENTATION HISTORY

A

TUBERCULIN SKIN TEST RECORD
0.1 ml of 5 tuberculin units (TU) purified protein derivative (PPD) antigen intradermal

DATED PLACED	STEP	MANUFACTURER	LOT #	EXP	SITE	*ADM BY (INITIALS)	DATE READ	*READ BY (INITIALS)	RESULT	STATUS Indicate: Reactor Non-Reactor Converter
	1st									
	2nd									

If either result is positive, send for CXR and complete Section C below.

OR

B	Negative BAMT (<12 months)	Date:	Results	☐ LA County ☐ Outside Document	**STATUS**

If CXR is positive for TB, DO NOT CLEAR for hire/assignment.
Refer Workforce Member for immediate medical care.

C	Positive TST	Date:	Results _____mm	☐ LA County ☐ Outside Document	**STATUS**
	CXR (<12 months)	Date:	Results_____	☐ LA County ☐ Outside Document	

OR

D	Positive BAMT	Date:	Results_____	☐ LA County ☐ Outside Document	**STATUS**
	CXR (<12 months)	Date:	Results_____	☐ LA County ☐ Outside Document	

OR

E	History of Active TB with Treatment	Date:	_____months with_____	☐ Outside Document	**STATUS**
	CXR (<12 months)	Date:	Results_____	☐ Outside Document	

OR

F	History of LTBI Treatment	Date:	_____months with_____	☐ Outside Document	**STATUS**
	CXR (<12 months)	Date:	Results_____	☐ Outside Document	

CONTINUE ON NEXT PAGE

B-NC

CONFIDENTIAL

TUBERCULOSIS HISTORY AND EVIDENCE OF IMMUNITY

LAST NAME	FIRST, MIDDLE NAME	BIRTHDATE	IDENTIFICATION NO.

G — IMMUNIZATION DOCUMENTATION HISTORY (THESE VACCINATIONS ARE MANDATORY)

	Date Received	Titer	If not immune, give Vaccination x 2, unless Rubella x 1		Date Received	Vaccine		Declined Vaccination
Measles		☐ Immune ☐ Non-Immune ☐ Equivocal ☐ Laboratory confirm of disease	**OR**	**X 2**			**OR**	☐ **If WFM declines, WFM must complete Form K-NC AND specify reason(s) for declination.**
Mumps		☐ Immune ☐ Non-Immune ☐ Equivocal ☐ Laboratory confirm of disease	**OR**	**X 2**			**OR**	☐ **If WFM declines, WFM must complete Form K-NC AND specify reason(s) for declination.**
Rubella		☐ Immune ☐ Non-Immune ☐ Equivocal ☐ Laboratory confirm of disease	**OR**	**X 1**			**OR**	☐ **If WFM declines, WFM must complete Form K-NC AND specify reason(s) for declination.**
Varicella		☐ Immune ☐ Non-Immune ☐ Equivocal ☐ Laboratory confirm of disease	**OR**	**X 2**			**OR**	☐ **If WFM declines, WFM must complete Form K-NC AND specify reason(s) for declination.**

AND

H

Vaccination	Date Received		Declined Vaccine
Tetanus-diphtheria (Td) Every 10 years		☐ Verbal ☐ Document	☐
Arcellular Pertussis (Tdap) X 1		☐ Verbal ☐ Document	☐

AND

I

Vaccination (MANDATORY for WFM who have potential to be exposed to blood or body fluid)	Date Received	Immunity	Declined Vaccine
Hepatitis B (HBsAb)		☐ Reactive ☐ Non reactive ☐ N/A	☐

AND

J

Vaccination (VOLUNTARY)	Date Received	Location Received		Declined Vaccine
Seasonal Influenza (Annually)			☐ Verbal ☐ Document	☐

ATTACH SUPPORTING DOCUMENTATION(S) WITH THIS FORM INCLUDING FORM K-NC IF WFM DECLINED VACCINATION(S)

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. 29 C.F.R. Part 1635

GENERAL INSTRUCTION ON NEXT PAGE

LAST NAME	FIRST, MIDDLE NAME	BIRTHDATE	IDENTIFICATION NO.

GENERAL INSTRUCTIONS FOR EACH SECTION

SECTION	
TUBERCULOSIS DOCUMENTATION HISTORY **ALL WORKFORCE MEMBER (WFM) SHALL BE SCREENED FOR TB UPON HIRE/ASSIGNMENT**	
A	WFM shall receive a baseline TB screening using two-step Tuberculin Skin Test (TST). Step 1: Administer TST test, with reading in seven days. Step 2: After Step 1 reading is negative, administer TST test, with reading within 48-72 hours. If both readings are negative, WFM is cleared to work. WFM shall receive either TST or BAMT and symptom screening annually. a. Documentation of negative TST within 12 months prior to placement will be accepted. WFM shall receive a one-step TST with reading within 48-72 hours. If result is negative, WFM is cleared to work; b. Documentation of negative two-step TST within 12 months prior to placement will be accepted. WFM is cleared to work. If TST is positive, record results and continue to Section C.
B	WFM shall receive a baseline TB screening using a single blood assay for M. tuberculosis (BAMT). If negative result, WFM is cleared to work. WFM shall receive either TST or BAMT and symptom screening annually. a. Documentation of negative BAMT within 12 months will be accepted. WFM is cleared to work. If BAMT is positive, record results and continue to Section D.
TST POSITIVE RESULTS **If CHEST X-RAY IS POSITIVE, <u>DO NOT CLEAR</u> FOR HIRE/ASSIGNMENT, AND** **REFER WORKFORCE MEMBER FOR IMMEDIATE MEDICAL CARE**	
C	If TST is positive during testing in Section A or C above, send for a chest x-ray (CXR). If CXR is negative, WFM is cleared to work. Documentation of negative CXR within 12 months prior to placement will be accepted for clearance to work. WFM shall be symptom screened for TB annually.
D	If BAMT is positive during testing in Section D above, send for a CXR. If CXR is negative, WMF is cleared to work. Documentation of negative CXR within 12 months prior to placement will be accepted for clearance to work. WFM shall be symptom screened for TB annually.
E	If WFM have a documented history of active TB, send for a chest x-ray (CXR). If CXR is negative, WFM is cleared to work. Documentation of negative CXR within 12 months prior to placement will be accepted for clearance to work. If documentation is supported, WFM is cleared to work. WFM shall be symptom screened for TB annually. Record documentation result in this section.
F	If WFM have a documented history of latent tuberculosis infection (LTBI) treatment, send for a chest x-ray (CXR). If CXR is negative, WFM is cleared to work. Documentation of negative CXR within 12 months prior to placement will be accepted for clearance to work. If documentation is supported, WFM is cleared to work. WFM shall be symptom screened for TB annually. Record documentation result in this section.
IMMUNIZATION DOCUMENTATION HISTORY Documentation of immunization or adequate titers will be accepted. If WFM is not immune against communicable diseases as listed in this section, WFM shall be immunized (unless medically contraindicated). WFM who declines the vaccination(s) must sign the mandatory declination form. WFM who declines the vaccination(s) may be restricted from patient care areas of the hospital or facility. If WFM is non-immune or decides at a later date to accept the vaccination, DHS or WFM contract agency will make the vaccination available.	
G	Documentation of laboratory evidence of immunity or laboratory confirmation of disease will be accepted **OR** documentation of two doses (live measles, mumps and varicella) and one dose of live rubella virus vaccine. Measles vaccine shall be administered no earlier than one month (minimum 28 days) after the first dose. Mumps second dose vaccine vary depending on state or local requirements. Varicella doses shall be at least 4 week between doses for WFM. If Equivocal, WFM needs either vaccination or re-draw with positive titer. **DHS-EHS must be notified if WFM does not demonstrate evidence of immunity.**
H	**<u>Td</u>** – After primary vaccination, Td booster is recommended every 10 years. If unvaccinated WFM, primary vaccination consists of 3 doses of Td; 4-6 weeks should separate the first and second doses; the third dose should be administered 6-12 months after the second dose. **<u>Tdap</u>** should replace a one time dose of Td for HCP aged 19 though 64 years who have not received a dose of Tdap previously. An interval as short as 2 years or less from the last dose of Td is recommended for the Tdap dose.
I	All WFM who have occupational exposure to blood or other potentially infectious materials shall have a documented post vaccination antibody to Hepatitis B surface antigen HBsAb (anti-HBs). Hepatitis B vaccine series is available to WFM. Non-responders should be considered susceptible to HBV and should be counseled regarding precautions to prevent HBV infection and the need to obtain HBIG prophylaxis for any known or probable parenteral exposure to HBsAg positive blood.
J	Seasonal influenza is offered annually to WFM when the vaccine becomes available.

This form and its attachment(s), if any, such as medical records shall be maintained and filed at non-DHS/non-County workforce member's School/Employer. The School/Employer shall verify completeness of DHS-Employee Health Services (EHS) form(s) and ensure confidentiality of non-DHS/non-County WFM health information.

Upon request by DHS-EHS, the non-DHS/non-County WFM School/Employer shall have this form and its attachment(s) readily available within four (4) hours.

All workforce member health records are confidential in accordance with federal, state and regulatory requirements.

K-NC

Health Services
LOS ANGELES COUNTY

EMPLOYEE HEALTH SERVICES

CONFIDENTIAL
NON-DHS/NON-COUNTY WORKFORCE MEMBER DECLINATION FORM

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	IDENTIFICATION NO.:	
JOB CLASSIFICATION:	DHS FACILITY:	DEPT/DIVISION:	WORK AREA/UNIT:	SHIFT:
NAME OF SCHOOL/EMPLOYER *(If applicable)*:		PHONE NO.:	CONTACT PERSON:	

Please check in the section(s) as apply AND indicate reason for the declination. Submit original to DHS-EHS.

I. ☐ 8 CCR §5199. Appendix C1 - Vaccination Declination Statement (Mandatory)*

Please check as apply: ☐ Measles ☐ Mumps ☐ Rubella ☐ Varicella ☐ Td/Tdap

I understand that due to my occupational exposure to aerosol transmissible diseases, I may be at risk of acquiring infection as indicated above. I have been given the opportunity to be vaccinated against this disease or pathogen at no charge to me. However, I decline this vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring the above infection, a serious disease. If in the future I continue to have occupational exposure to aerosol transmissible diseases and want to be vaccinated, I can receive the vaccination from my School/Employer or DHS-Employee Health Services (EHS) at no charge to me.

Reason for declination: _____

_____

☐ Seasonal Influenza

Reason for declination *(check as apply):*

☐ I am allergic to vaccine components.
☐ I believe I can get the flu if I get the shot.
☐ I am concerned about vaccine side effects.
☐ It's against my personal belief.
☐ I don't believe I need it.
☐ I'm concerned about vaccine safety.
☐ I do not like needles.
☐ Other: _____

II. ☐ 8 CCR §5193. Appendix A-Hepatitis B Vaccine Declination (Mandatory)*

☐ Hepatitis B

I understand that due to my occupational exposure to blood or other potentially infectious material (OPIM) I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to me. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or OPIM and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series from my School/Employer or DHS-EHS at no charge to me.

Reason for declination: _____

_____

III. ☐ Specialty Surveillance Declination (Mandatory)**

Please check as apply: ☐ Asbestos ☐ Hazardous/Anti-Neoplastic Drugs ☐ Other:_____

I understand that due to my occupational exposure as indicated above, I am eligible and have been given the opportunity to enroll in the Medical Surveillance Program. This will enable me to receive specific initial, periodic

PLEASE SIGN ON PAGE 2

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	IDENTIFICATION NO.:

and exit medical examinations for the hazard identified above, at no charge to me and at a reasonable time and place.

However, I decline to be enrolled in this program at this time. I understand that by declining this enrollment, I will not be medically monitored for occupational exposure to this hazard. I understand that it is strongly recommended that I complete a medical questionnaire or examination. I also understand that if in the future I continue to have occupational exposure to the hazard identified above and I want to be enrolled in the Medical Surveillance Program, I can do so at any time at no charge to me.

Reason for declination: _____

_____

SIGN BELOW

By signing this, I am declining as indicated on this form.

WORKFORCE MEMBER SIGNATURE		DATE
SCHOOL/EMPLOYER (PRINT NAME)	**SIGNATURE**	**DATE**

MAKE A COPY FOR YOUR RECORDS
SUBMIT ORIGINAL AND ANY SUPPORTING DOCUMENT(S)

*Vaccination(s) is available to all workforce members (WFM), and free of charge for County employees and volunteers. Non-County WFM should obtain the vaccinations from their physician or licensed health care professional. Services provided through DHS will be billed to the non-County WFM School/Employer, as appropriate.

**Non-County WFM who has potential exposure to occupational hazards will be included in the surveillance program, but will not have their assessments done through the County, unless specified in contract/agreement. Medical surveillance/post-exposure regulations are the responsibility of the school/contract agency. If the non-County WFM School/Employer chooses to have DHS-Employee Health Services (EHS) to perform such surveillance/post-exposure services, the non-County WFM School/Employer will be billed accordingly. Emergency services will be provided post-exposure within the allowable time frames, but will be billed to the contractor/agency, as appropriate.

Workforce member must complete this form if declining DHS recommended and mandatory vaccinations or medical surveillance program. The School/Employer must verify completeness and ensure declination form is submitted to DHS-EHS. **The School/Employer must notify DHS-EHS if workforce member does not provide evidence of immunity.**

This form and its attachment(s), if any, such as health records shall be maintained and kept in workforce member EHS health file.

N-NC

Health Services
LOS ANGELES COUNTY

EMPLOYEE HEALTH SERVICES

NON-DHS/NON-COUNTY WORKFORCE MEMBER RESPIRATORY FIT TEST RECORD

☞ **GENERAL INFORMATION ON LAST PAGE**

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	IDENTIFICATION NO.:

JOB CLASSIFICATION:	DHS FACILITY:	DEPT/DIVISION:	WORK AREA/UNIT:	SHIFT:

E-MAIL ADDRESS:	WORK PHONE NO.:	CELL/PAGER NO.:	SUPERVISOR NAME:

NAME OF SCHOOL/EMPLOYER *(If applicable)*:	PHONE NO.:	CONTACT PERSON:

RESPIRATOR, QUESTIONNAIRE, MEDICAL EVALUATION

EQUIPMENT TYPE:	MANUFACTURER:	MODEL:	SIZE:
N-95	**Kimberly-Clark**	☐ **PFR95-174** ☐ **PFR95-170**	☐ **Small** ☐ **Regular**

Based on review of the respirator health questionnaire: ☐ 8 CCR §5144 (Form O-NC) ***OR*** ☐ 8 CCR §5199 (Form P-NC), this individual is:

☐ Medically approved for only the following types of respirator subject to satisfactory fit test:

- ☐ 1. Disposable Particulate Respirators
- ☐ 2. Replaceable Disposable Particulate Respirators: ☐ a. Half-Facepiece ☐ b. Full-Facepiece
- ☐ 3. Powered Air Purifying Respirators (PAPRs): ☐ a. Tight Fitting
- ☐ 4. Self-Contained Breathing Apparatus (SCBA)

Recommended time period for next questionnaire: ☐ 4 years ☐ Other _____ with justification _____

Date Completed: _____ Next Due Date: _____

List any facial fit problem conditions that apply to you (e.g., beard growth, sideburns, scars, deep wrinkles): _____

TASTE THRESHOLD SCREENING (NO food, drink, smoke, gum X 15 minutes before testing)

(Bitrex or Saccharin): ☐ X 10 ☐ X 20 ☐ X 30 ☐ Fail

RESPIRATOR FIT, PRESSURE FIT CHECK, COMFORT

	ATTEMPT #1	ATTEMPT #2	ATTEMPT #3
Fit Check: ☐ **POSITIVE** and/or	☐ Pass ☐ Fail	☐ Pass ☐ Fail	☐ Pass ☐ Fail
☐ **NEGATIVE** pressure	☐ Pass ☐ Fail	☐ Pass ☐ Fail	☐ Pass ☐ Fail
Overall Comfort Level	☐ Pass ☐ Fail	☐ Pass ☐ Fail	☐ Pass ☐ Fail
Ability to Wear Eyeglasses	☐Pass ☐Fail ☐NA	☐Pass ☐Fail ☐NA	☐Pass ☐Fail ☐NA

FIT TEST

	ATTEMPT #1	ATTEMPT #2	ATTEMPT #3
Normal Breathing *(performed for one minute)*	☐ Pass ☐ Fail	☐ Pass ☐ Fail	☐ Pass ☐ Fail
Deep Breathing *(performed for one minute)*	☐ Pass ☐ Fail	☐ Pass ☐ Fail	☐ Pass ☐ Fail
Turning Head Side to Side *(performed for one minute)*	☐ Pass ☐ Fail	☐ Pass ☐ Fail	☐ Pass ☐ Fail
Moving Head Up and Down *(performed for one minute)*	☐ Pass ☐ Fail	☐ Pass ☐ Fail	☐ Pass ☐ Fail
Talking – Rainbow Passage *(performed for one minute)*	☐ Pass ☐ Fail	☐ Pass ☐ Fail	☐ Pass ☐ Fail
Bending Over *(performed for one minute)*	☐ Pass ☐ Fail	☐ Pass ☐ Fail	☐ Pass ☐ Fail
Normal Breathing *(performed for one minute)*	☐ Pass ☐ Fail	☐ Pass ☐ Fail	☐ Pass ☐ Fail

COMMENTS: _____

CONTINUE ON NEXT PAGE

N-NC

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	IDENTIFICATION NO.:

☐ Workforce member failed fit testing. A powered air-purifying respirator (PAPR) must be provided to workforce member.
☐ WFM trained on PAPR use. ☐ N/A

☐ **PASS Pre-Placement FIT Test on:** _____ ☐ **PASS Annual FIT Test on:** _____

ACKNOWLEDGMENT OF TEST RESULTS

I have undergone fit testing on the above respirator. I have been instructed in and understand the proper fitting, use and care of the respirator.

Signature of Non-County/DHS Workforce Member:_____ Date:_____

FIT Test Trainer (Print Name):_____ Signature:_____ Date:_____

DHS-EHS OFFICE STAFF ONLY			
Completion of this form:	Reviewed By (Print)	Signature	Date

GENERAL INFORMATION

Pursuant to Title 8 of the California Code of Regulations, Sections 5144 and 5199 (8 CCR §5144 and §5199), all workforce member (WFM) who are required to use respiratory protection must be fit tested with the same make, model, style, and size of respirator to be used. Fit testing procedures for respirators must be conducted for the following:

- Initial fit test must be conducted after the WFM has passed medical evaluation and clearance.
- Newly hired/assigned workforce members who have passed medical evaluation and clearance.
- When new style of respirator face piece is to be worn by WFM.
- Annual fit test for all WFM required to wear a respirator.
- WFM reports, or the Physician or Licensed Health Care Professional (PLHCP), supervisor, or Program Administrator makes visual observations of changes in the workforce member's physical condition that could affect respirator fit. Such conditions include, but are not limited to, facial scarring, facial hair, dental changes, cosmetic surgery, or an obvious change in body weight.
- WFM must be given a reasonable opportunity to select a different respirator face piece and be re-fit tested, if required.
- If WFM is unable to be fit-tested or has failed the fit test, WFM must be provided with a powered air-purifying respirator (PAPR).

This form and its attachment(s), if any, such as medical records shall be maintained and filed at non-DHS/non-County WFM School/Employer. The School/Employer shall verify completeness of DHS-Employee Health Services (EHS) form(s) and ensure confidentiality of non-DHS/non-County WFM medical information.

Upon request by DHS-EHS, the non-DHS/non-County WFM School/Employer shall have this form and its attachment(s) readily available within four (4) hours.

All workforce member health records are confidential in accordance with federal, state and regulatory requirements.

DHS-EHS will obtain the workforce member's written authorization before using or disclosing health information, include to self, unless the disclosure is required by State or Federal law such as to a public health authority or governmental regulatory agency.

Workforce members have the right to access their medical records and obtain a copy, thereof, within fifteen (15) days after the request.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. 29 CFR Part 1635

O-NC Health Services
LOS ANGELES COUNTY

EMPLOYEE HEALTH SERVICES

CONFIDENTIAL
NON-DHS/NON-COUNTY WORKFORCE MEMBER
8 CCR SECTION 5144 – APPENDIX C
RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

Questionnaire for respirators greater than N-95

☞ **GENERAL INFORMATION on last page**

WORKFORCE MEMBER TO COMPLETE ONCE EVERY FOUR (4) YEARS OR AS NEEDED

To the EMPLOYER:
Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination.

To the WORKFORCE MEMBER:
Can you read and understand this questionnaire (check one): ☐ Yes ☐ No

Your employer must allow you to answer the questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

SECTION 1 – PART A (MANDATORY)
The following information must be provided by every workforce member who has been selected to use any type of respirator (please print).

TODAY'S DATE:			
LAST NAME	FIRST, MIDDLE NAME	BIRTHDATE	GENDER ☐ MALE ☐ FEMALE
HEIGHT FT IN	WEIGHT LBS	JOB CLASSIFICATION	IDENTIFICATION NO.
PHONE NUMBER	Best Time to reach you?	Has your employer told you how to contact the health care professional who will review this questionnaire? ☐ Yes ☐ No	

Check type of respirator you will use (you can check more than one category): ☐ N, R, Or P disposal respirator (filter-mask, non-cartridge type only) ☐ Other type (specify): _____	
Have you worn a respirator? ☐ Yes ☐ No	If "yes", what type:

SECTION 2 – PART A (MANDATORY)
Questions 1 through 9 below must be answered by every workforce member who has been selected to use any type of respirator (please check "YES," "NOT SURE," or "NO").

YES	NOT SURE	NO	
☐	☐	☐	1. Do you currently smoke tobacco, or have you smoked tobacco in the last month?
			2. Have you ever had any of the following conditions:
☐	☐	☐	a. Seizures (fits)
☐	☐	☐	b. Diabetes (sugar disease)
☐	☐	☐	c. Allergic reactions that interfere with your breathing
☐	☐	☐	d. Claustrophobia (fear of closed-in places)
☐	☐	☐	e. Trouble smelling odors

CONTINUE ON NEXT PAGE

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	IDENTIFICATION NO.:

YES	NOT SURE	NO	
			3. Have you ever had any of the following pulmonary or lung problems:
☐	☐	☐	a. Asbestosis
☐	☐	☐	b. Asthma
☐	☐	☐	c. Chronic brochitis
☐	☐	☐	d. Emphysema
☐	☐	☐	e. Pneumonia
☐	☐	☐	f. Tuberculosis
☐	☐	☐	g. Silicosis
☐	☐	☐	h. Pneumothorax (collapsed lung)
☐	☐	☐	i. Lung cancer
☐	☐	☐	j. Broken ribs
☐	☐	☐	k. Any chest injuries or surgeries
☐	☐	☐	l. Any other lung problem that you've been told about?
			If "YES," please explain:
			4. Do you currently have any of the following symptoms of pulmonary or lung illness:
☐	☐	☐	a. Shortness of breath
☐	☐	☐	b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline
☐	☐	☐	c. Shortness of breath when walking with other people at an ordinary pace on level ground
☐	☐	☐	d. Have to stop for breath when walking at your own pace on level ground
☐	☐	☐	e. Shortness of breath when washing or dressing yourself
☐	☐	☐	f. Shortness of breath that interferes with your job
☐	☐	☐	g. Coughing that produces phlegm (thick sputum)
☐	☐	☐	h. Coughing that wakes you early in the morning
☐	☐	☐	i. Coughing that occurs mostly when you are lying down
☐	☐	☐	j. Coughing up blood in the last month
☐	☐	☐	m. Chest pain when you breathe deeply
☐	☐	☐	n. Any other symptoms that you think may be related to lung problems?
			If "YES," please list symptoms:
			5. Have you ever had any of the following cardiovascular or heart problems:
☐	☐	☐	a. Heart attack
☐	☐	☐	b. Stroke
☐	☐	☐	c. Angina
☐	☐	☐	d. Heart failure
☐	☐	☐	e. Swelling in your legs or feet (not caused by walking)
☐	☐	☐	f. Heart arrhythmia (heart beating irregularly)
☐	☐	☐	g. High blood pressure
☐	☐	☐	h. Any other heart problem that you've been told about?
			If "YES," please explain:

CONTINUE ON NEXT PAGE

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	IDENTIFICATION NO.:

YES	NOT SURE	NO	
			6. Have you ever had any of the following cardiovascular or heart symptoms:
☐	☐	☐	a. Frequent pain or tightness in your chest
☐	☐	☐	b. Pain or tightness in your chest during physical activity
☐	☐	☐	c. Pain or tightness in your chest that interferes with your job
☐	☐	☐	d. In the past two years, have you noticed your heart skipping or missing a beat?
☐	☐	☐	e. Heartburn or indigestion that is not related to eating
☐	☐	☐	f. Any other symptoms that you think may be related to heart or circulation problems?
			If "YES," please list symptoms:
			7. Do you currently take medication for any of the following problems?
☐	☐	☐	a. Breathing or lung problems
☐	☐	☐	b. Heart trouble
☐	☐	☐	c. Blood pressure
☐	☐	☐	d. Seizures (fits)
			8. If you've ever used a respirator, have you ever had any of the following problems?
☐	☐	☐	a. Eye irritation
☐	☐	☐	b. Skin allergies or rashes
☐	☐	☐	c. Anxiety
☐	☐	☐	d. General weakness or fatigue
☐	☐	☐	e. Any other problem that interferes with your use of a respirator?
			If "YES," please explain:
☐	☐	☐	9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?

SECTION 2 – PART B ☐ **NOT APPLICABLE**

Questions 10 through 15 below must be answered by every workforce member who has been selected to use either a full-face piece respirator or a self-contained breathing apparatus (SCBA). For workforce members who have been selected to use other types of respirators, answering these questions is **VOLUNTARY.**

YES	NOT SURE	NO	
☐	☐	☐	10. Have you ever lost vision in either eye (temporarily or permanently)?
			11. Do you currently have any of the following vision problems:
☐	☐	☐	a. Wear contact lenses
☐	☐	☐	b. Wear glasses
☐	☐	☐	c. Color blind
☐	☐	☐	d. Any other eye or vision problem?
			If "YES," please explain:
☐	☐	☐	12. Have you ever had an injury to your ears, including a broken ear drum?
			13. Do you currently have any of the following hearing problem:

CONTINUE ON NEXT PAGE

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	IDENTIFICATION NO.:

YES	NOT SURE	NO	
☐	☐	☐	a. Difficulty hearing
☐	☐	☐	b. Wear a hearing aid
☐	☐	☐	c. Any other hearing or ear problem
			If "YES," please explain:
☐	☐	☐	14. Have you ever had a back injury?
			15. Do you currently have any of the following musculoskeletal problems:
☐	☐	☐	a. Weakness in any of your arms, hands, legs, or feet
☐	☐	☐	b. Back pain
☐	☐	☐	c. Difficulty fully moving your arms and legs
☐	☐	☐	d. Pain and stiffness when you lean forward or backward at the waist
☐	☐	☐	e. Difficulty fully moving your head up or down
☐	☐	☐	f. Difficulty fully moving your head side to side
☐	☐	☐	g. Difficulty bending at your knees
☐	☐	☐	h. Difficulty squatting to the ground
☐	☐	☐	i. Climbing a flight of stairs or a ladder carrying more than 25 lbs.
☐	☐	☐	j. Any other muscle or skeletal problem that interferes with using a respirator?
			If "YES," please explain:

SECTION 2 – PART C ☐ **NOT APPLICABLE**

Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

YES	NOT SURE	NO	
☐	☐	☐	1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen?
☐	☐	☐	If "YES," do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you're working under these conditions?
☐	☐	☐	2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals.
			If "YES," name the chemicals if you know them: a. _____ d. _____ b. _____ e. _____ c. _____ f. _____
			3. Have you ever worked with any of the materials, or under any of the conditions, listed below:
☐	☐	☐	a. Asbestos
☐	☐	☐	b. Silica (e.g., in sandblasting)
☐	☐	☐	c. Tungsten/cobalt (e.g., grinding or welding this material)
☐	☐	☐	d. Beryllium
☐	☐	☐	e. Aluminum

CONTINUE ON NEXT PAGE

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	IDENTIFICATION NO.:

YES	NOT SURE	NO	
☐	☐	☐	f. Coal (for example, mining)
☐	☐	☐	g. Iron
☐	☐	☐	h. Tin
☐	☐	☐	i. Dusty environment
☐	☐	☐	j. Any other hazardous exposures? If "YES," describe these exposure:
			4. List any second jobs or side businesses you have: a. _____ d. _____ b. _____ e. _____ c. _____ f. _____
			5. List your previous occupations: a. _____ d. _____ b. _____ e. _____ c. _____ f. _____
			6. List your current and previous hobbies: a. _____ d. _____ b. _____ e. _____ c. _____ f. _____
☐	☐	☐	7. Have you been in the military services?
☐	☐	☐	If "YES," were you exposed to biological or chemical agents (either in training or combat)? Please list chemicals (if known): a. _____ d. _____ b. _____ e. _____ c. _____ f. _____
☐	☐	☐	8. Have you ever worked on a HAZMAT team?
☐	☐	☐	9. Other than medications for breathing and lung problems, heart troubles, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications)? If "YES," name the medications if you know them: a. _____ e. _____ b. _____ f. _____ c. _____ g. _____ d. _____ h. _____
			10. Will you be using any of the following items with your respirator(s)?
☐	☐	☐	a. HEPA Filters
☐	☐	☐	b. Canisters (for example, gas masks)
☐	☐	☐	c. Cartridges
			11. How often are you expected to use the respirator(s)? Check "YES", "NOT SURE," or "NO" to all answers that apply to you.

CONTINUE ON NEXT PAGE

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	IDENTIFICATION NO.:

YES	NOT SURE	NO	
☐	☐	☐	a. Escape only (no rescue)
☐	☐	☐	b. Emergency rescue only
☐	☐	☐	c. Less than 5 hours per week
☐	☐	☐	d. Less than 2 hours per day
☐	☐	☐	e. 2 to 4 hours per day
☐	☐	☐	f. Over 4 hours per day
			12. During the period you are using the respirator(s), is your work effort:
☐	☐	☐	a. Light (less than 200 kcal per hour) If "YES," how long does this period last during the average shift:_____hrs. _____mins. *Examples of a light work effort are sitting while writing, typing, drafting, or performing light assembly work; or standing while operating a drill press (1-3 lbs.) or controlling machines.*
☐	☐	☐	b. Moderate (200 to 350 kcal per hour) If "YES," how long does this period last during the average shift:_____hrs. _____mins. *Examples of moderate work effort are sitting while nailing or filing; driving a truck or bus in urban traffic; standing while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; walking on a level surface about 2 mph or down a 5-degree grade about 3 mph; or pushing a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.*
☐	☐	☐	c. Heavy (above 350 kcal per hour) If "YES," how long does this period last during the average shift:_____hrs. _____mins. *Examples of heavy work are lifting a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; shoveling; standing while bricklaying or chipping castings; walking up an 8- degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.).*
☐	☐	☐	13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using the respirator? If "YES," describe this protective clothing and/or equipment: a._____ e._____ b._____ f._____ c._____ g._____ d._____ h._____
☐	☐	☐	14. Will you be working under hot conditions (temperature exceeding 77 degrees Fahrenheit)?
☐	☐	☐	15. Will you be working under humid conditions?

16. Describe the work you'll be doing while you're using your respirator(s):

17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (for example, confined spaces, life-threatening gases):

CONTINUE ON NEXT PAGE

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	IDENTIFICATION NO.:

18. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're using your respirator(s):

Name of toxic substances	Estimated maximum exposure level per shift:	Duration of exposure per shift
a.	a.	a.
b.	b.	b.
c.	c.	c.
d.	d.	d.
e.	e.	e.
f.	f.	f.

The name of any other toxic substances that you'll be exposed to while using your respirator(s):

19. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue, security):

Non-DHS/Non-County Workforce Member Signature	Date

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. 29 C.F.R. Part 1635

PHYSICIAN OR LICENSED HEALTH CARE PROFESSIONAL TO COMPLETE NEXT PAGE

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	IDENTIFICATION NO.:

FOR COMPLETION BY A PHYSICIAN OR LICENSED HEALTH CARE PROFESSIONAL
PROVIDE A COPY OF THIS PAGE TO THE WORKFORCE MEMBER

PART 1: Fit Testing Recommendation – Based on Questionnaire

☐ Questionnaire above reviewed.
☐ Medical approval to receive Fit Test:
1. ☐ Disposable Particulate Respirators (N-95)
2. ☐ Replaceable Disposable Particulate Respirator ☐ a. Half-Facepiece ☐ b. Full Facepiece
3. ☐ Powered Air-Purifying Respirators (PAPRs) ☐ a. Tight Fitting
4. ☐ Self-Contained Breathing Apparatus (SCBA)

Recommended time period for next questionnaire: ☐ 4 years ☐ Other _____ with justification _____

Date Completed: _____ Next Due Date: _____

Any recommended limitations for respirator use on workforce member: _____

☐ The above workforce member has not been cleared to be fit tested for a respirator.
- ☐ Additional medical evaluation is needed. Physician or Licensed Health Care Professional to complete Part 2 below.
- ☐ Medically unable to use a respirator.

☐ Informed workforce member of the results of this examination.

Comments: _____

PART 2: Additional Medical Evaluations ☐ Not Applicable

☐ Medical evaluation completed.
☐ Medical Approval to Receive Fit Test:
1. ☐ Disposable Particulate Respirators (N-95)
2. ☐ Replaceable Disposable Particulate Respirator ☐ a. Half-Facepiece ☐ b. Full Facepiece
3. ☐ Powered Air-Purifying Respirators (PAPRs) ☐ a. Tight Fitting
4. ☐ Self-Contained Breathing Apparatus (SCBA)

Recommended time period for next questionnaire: ☐ 4 years ☐ Other _____ with justification _____

Date Completed: _____ Next Due Date: _____

Any recommended limitations for respirator use on workforce member: _____

☐ Medically unable to use a respirator.

☐ Informed workforce member of the results of this examination.

Comments: _____

Non-DHS/Non-County Workforce Member Signature		Date	
Physician or Licensed Health Care Professional Signature	Print Name	License No.	Date
Facility Name/Address		Phone No.	

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	IDENTIFICATION NO.:

DHS-EHS OFFICE STAFF ONLY			
Completion of this form:	Reviewed By (Print)	Signature	Date

GENERAL INFORMATION

THIS QUESTIONNAIRE IS TO BE REVIEWED BY A PHYSICIAN OR LICENSED HEALTH CARE PROFESSIONAL.

8 CCR §5144

1. General. DHS-EHS or non-DHS/non-County workforce member's (WFM) School/Employer shall provide a medical evaluation to determine the WFM ability to use a respirator, before the WFM is fit tested or required to use the respirator in the workplace. DHS-EHS may discontinue a WFM's medical evaluations when the WFM is no longer required to use a respirator.
2. Medical evaluation procedures.
   a. DHS-EHS or non-DHS/non-County WFM School/Employer shall identify a physician or other licensed health care professional (PLHCP) to perform medical evaluations using a medical questionnaire or an initial medical examination that obtains the same information as the medical questionnaire.
   b. The medical evaluation shall obtain the information requested by this questionnaire in Sections 1 and 2, Part
3. Follow-up medical examination.
   a. DHS-EHS or non-DHS/non-County WFM School/Employer shall ensure that a follow-up medical examination is provided for a non-DHS/non-County WFM who gives a **positive response to any question among questions 1 through 8 in Section 2, Part A** of this questionnaire or whose initial medical examination demonstrates the need for a follow-up medical examination.
   b. The follow-up medical examination shall include any medical tests, consultations, or diagnostic procedures that the PLHCP deems necessary to make a final determination.

If WFM is unable to be fit-tested or has failed the fit test, WFM must be provided with a powered air-purifying respirator (PAPR).

This form and its attachment(s), if any, such as medical records shall be maintained and filed at non-DHS/non-County WFM School/Employer. The School/Employer shall verify completeness of DHS-EHS form(s) and ensure confidentiality of non-DHS/non-County WFM health information.

Upon request by DHS-Employee Health Services (EHS), the non-DHS/non-County WFM School/Employer shall have this form and its attachment(s) readily available within four (4) hour. All non-DHS/non-County workforce member health records are confidential in accordance with federal, state and regulatory requirements.

Health records will be maintained by DHS-EHS or non-County WFM School/Employer and kept for thirty (30) years after the workforce member's employment/assignment ends, in accordance with State and Federal medical records standards and DHS policies and procedures.

DHS-EHS will obtain the workforce member's written authorization before using or disclosing medical information, include to self, unless the disclosure is required by State or Federal law such as to a public health authority or governmental regulatory agency.

Workforce members have the right to access their medical records and obtain a copy, thereof, within fifteen (15) days after the request.

A copy of the respiratory protection regulation Title 8 CCR §5144 and §5199 can be found at http://www.dir.ca.gov/title8/5144.html and http://www.dir.ca.gov/Title8/5199.html

P-NC

Health Services
LOS ANGELES COUNTY

EMPLOYEE HEALTH SERVICES

CONFIDENTIAL
NON-DHS/NON-COUNTY WORKFORCE MEMBER
8 CCR SECTION 5199 – APPENDIX B
ATD RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

☞ **GENERAL INFORMATION on last page**

Questionnaire for N-95 Respirator

COMPLETE ONCE EVERY FOUR (4) YEARS OR AS NEEDED

This Appendix is Mandatory if the Employer chooses to use a Respirator Medical Evaluation Questionnaire other than the Questionnaire in Section 5144 Appendix C (Form O-NC).

To the PHYSICIAN OR LICENSED HEALTH CARE PROFESSIONAL: Answers to questions in Section 1, and to question 6 in Section 2 do not require a medical examination. Workforce member must be provided with a confidential means of contacting the health care professional who will review this questionnaire.

To the WORKFORCE MEMBER: Can you read and understand this questionnaire (check one): ☐ Yes ☐ No

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Please complete this questionnaire in PEN and present to the staff at the examination clinic. **To protect your confidentiality, it should not be given or shown to anyone else.** On the day of your appointment, you must bring a valid driver's license or other form of identification which has both your photograph and signature.

SECTION 1

The following information must be provided by every workforce member who has been selected to use any type of respirator (please print).

		TODAY'S DATE:	
LAST NAME	FIRST, MIDDLE NAME	BIRTHDATE	GENDER ☐ MALE ☐ FEMALE
HEIGHT FT IN	WEIGHT LBS	JOB CLASSIFICATION	IDENTIFICATION NO.
PHONE NUMBER	Best Time to reach you?	Has your employer told you how to contact the health care professional who will review this questionnaire? ☐ Yes ☐ No	

Check type of respirator you will use (you can check more than one category): ☐ N, R, Or P disposal respirator (filter-mask, non-cartridge type only) ☐ Other type (specify): _____	
Have you worn a respirator? ☐ Yes ☐ No	If "yes", what type:

SECTION 2

Questions 1 through 6 below must be answered by every workforce member who has been selected to use any type of respirator (please check "YES", "NOT SURE" or "NO").

YES	NOT SURE	NO	
			1. Have you ever had the following conditions?
☐	☐	☐	a. Allergic reactions that interfere with your breathing?
			If "yes," what did you react to? _____

CONTINUE ON NEXT PAGE

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	IDENTIFICATION NO.:

YES	NOT SURE	NO	
☐	☐	☐	b. Claustrophobia (fear of closed-in places)
			2. **Do you currently have any of the following symptoms of pulmonary or lung illness:**
☐	☐	☐	a Shortness of breath when walking fast on level ground or walking up a slight hill or incline
☐	☐	☐	b. Have to stop for breath when walking at your own pace on level ground
☐	☐	☐	c. Shortness of breath that interferes with your job
☐	☐	☐	d. Coughing that produces phlegm (thick sputum)
☐	☐	☐	e. Coughing up blood in the last month
☐	☐	☐	f. Wheezing that interferes with your job
☐	☐	☐	g. Chest pain when you breath deeply
☐	☐	☐	h. Any other symptoms that you think may be related to lung problems:_____
			3. **Do you currently have any of the following cardiovascular or heart symptoms?**
☐	☐	☐	a. Frequent pain or tightness in your chest
☐	☐	☐	b. Pain or tightness in your chest during physical activity
☐	☐	☐	c. Pain or tightness in your chest that interferes with your job
☐	☐	☐	d. Any other symptoms that you think may be related to heart problems:_____
			4. **Do you currently take medication for any of the following problems?**
☐	☐	☐	a. Breathing or lung problems
☐	☐	☐	b. Heart trouble
☐	☐	☐	c. Nose, throat or sinuses
☐	☐	☐	d. Are your problems under control with these medications?
			5. **If you've used a respirator, have you ever had any of the following problems while respirator is being used?** ***(If you've never used a respirator, check the following space and go to question 6).***
☐	☐	☐	a. Skin allergies or rashes
☐	☐	☐	b. Anxiety
☐	☐	☐	c. General weakness or fatigue
☐	☐	☐	d. Any other problem that interferes with your use of a respirator
☐	☐	☐	6. **Would you like to talk to the health care professional about your answers in this questionnaire?**

Non-DHS/Non-County Workforce Member Signature	Date

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. 29 CFR Part 1635

PHYSICIAN OR LICENSED HEALTH CARE PROFESSIONAL TO COMPLETE NEXT PAGE

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	IDENTIFICATION NO.:

FOR COMPLETION BY A PHYSICIAN OR LICENSED HEALTH CARE PROFESSIONAL
PROVIDE A COPY OF THIS PAGE TO THE WORKFORCE MEMBER

Part 1: Fit Testing Recommendation – Based on Questionnaire

☐ Questionnaire above reviewed.
☐ Medical Approval to Receive Fit Test
1. ☐ Disposable Particulate Respirators (N-95)
2. ☐ Replaceable Disposable Particulate Respirator ☐ a. Half-Facepiece ☐ b. Full Facepiece
3. ☐ Powered Air-Purifying Respirators (PAPRs) ☐ a. Tight Fitting
4. ☐ Self-Contained Breathing Apparatus (SCBA)

Recommended time period for next questionnaire: ☐ 4 years ☐ Other _____ with justification _____

Date Completed: _____ Next Due Date: _____

Any recommended limitations for respirator use on workforce member: _____

☐ The above workforce member has not been cleared to be fit tested for a respirator.
- ☐ Additional medical evaluation is needed. Physician or Licensed Health Care Professional to complete Part 2 below.
- ☐ Medically unable to use a respirator.

☐ Informed workforce member of the results of this examination.

Comments: _____

Part 2: Additional Medical Evaluations ☐ NOT APPLICABLE

☐ Medical evaluation completed.
☐ Medical Approval to Receive Fit Test
1. ☐ Disposable Particulate Respirators (N-95)
2. ☐ Replaceable Disposable Particulate Respirator ☐ a. Half-Facepiece ☐ b. Full Facepiece
3. ☐ Powered Air-Purifying Respirators (PAPRs) ☐ a. Tight Fitting
4. ☐ Self-Contained Breathing Apparatus (SCBA)

Recommended time period for next questionnaire: ☐ 4 years ☐ Other _____ with justification _____

Date Completed: _____ Next Due Date: _____

Any recommended limitations for respirator use on workforce member: _____

☐ Medically unable to use a respirator.

☐ Informed workforce member of the results of this examination.

Comments: _____

Non-DHS/Non-County Workforce Member Signature		Date	
Physician or Licensed Health Care Professional Signature	Print Name	License No.	Date
Facility Name/Address		Phone No.	

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	IDENTIFICATION NO.:

DHS-EHS OFFICE STAFF ONLY			
Completion of this form:	Reviewed By (Print)	Signature	Date

GENERAL INFORMATION

THIS QUESTIONNAIRE IS TO BE REVIEWED BY A PHYSICIAN OR LICENSED HEALTH CARE PROFESSIONAL.

8 CCR §5199
Medical evaluation: DHS-EHS or non-DHS/non-County workforce member (WFM) School/Employer shall provide a medical evaluation, in accordance with 8 CCR §5144(e) of these orders, to determine the workforce member's (WFM) ability to use the respirator before the WFM is fit tested or required to use the respirator. For WFM who use respirators solely for compliance with subsections (g)(3)(A) and subsections (g)(3)(B), this alternate questionnaire may be used.

8 CCR §5144(e)

1. General. DHS-EHS or non-DHS/non-county WFM School/Employer shall provide a medical evaluation to determine the WFM's ability to use a respirator, before the WFM is fit tested or required to use the respirator in the workplace. DHS-EHS may discontinue a WFM's medical evaluations when the WFM is no longer required to use a respirator.
2. Medical evaluation procedures.
   a. DHS-EHS or non-DHS/non-County WFM School/Employer shall identify a physician or other licensed health care professional (PLHCP) to perform medical evaluations using a medical questionnaire or an initial medical examination that obtains the same information as the medical questionnaire.
   b. The medical evaluation shall obtain the information requested by this questionnaire in Sections 1 and 2, Part A.
3. Follow-up medical examination.
   a. DHS-EHS or non-DHS/non-County WFM School/Employer shall ensure that a follow-up medical examination is provided for a WFM who gives a **positive response to any question among questions 1 through 8 in Section 2, Part A** of this questionnaire or whose initial medical examination demonstrates the need for a follow-up medical examination.
   b. The follow-up medical examination shall include any medical tests, consultations, or diagnostic procedures that the PLHCP deems necessary to make a final determination.

If WFM is unable to be fit-tested or has failed the fit test, WFM must be provided with a powered air-purifying respirator (PAPR).

This form and its attachment(s), if any, such as medical records shall be maintained and filed at non/DHS/non-County WFM School/Employer. The School/Employer shall verify completeness of DHS-EHS form(s) and ensure confidentiality of non-DHS/non-County WFM health information.

Upon request by DHS-Employee Health Services (EHS), the non-DHS/non-County WFM School/Employer shall have this form and its attachment(s) readily available within four (4) hours.

All workforce member health records are confidential in accordance with federal, state and regulatory requirements.

Health records will be maintained by DHS-EHS or non-DHS/non-County WFM School/Employer and kept for thirty (30) years after the workforce member's employment/assignment ends, in accordance with State and Federal medical records standards and DHS policies and procedures.

DHS-EHS will obtain the workforce member's written authorization before using or disclosing medical information, include to self, unless the disclosure is required by State or Federal law such as to a public health authority or governmental regulatory agency.

Workforce members have the right to access their medical records and obtain a copy, thereof, within fifteen (15) days after the request.

A copy of the respiratory protection regulation Title 8 CCR §5144 and §5199 can be found at http://www.dir.ca.gov/title8/5144.html and http://www.dir.ca.gov/Title8/5199.html